RECOMMENDATIONS TO THE CONGRESS

BY

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

"Access to Health Care and Long-Term Care for All Americans"

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The Pepper Commission Reports

Summary: Recommendations on Access to Health Care

THE PEPPER COMMISSION PROPOSAL ASSURES UNIVERSAL HEALTH CARE COVERAGE FOR ALL AMERICANS THROUGH A JOB-BASED/PUBLIC SYSTEM.

1. Businesses with 100 or fewer employees are encouraged to provide health insurance for their employees and non-working dependents.

   * To make insurance more available and affordable:

     -- The private insurance market is reformed.
     -- A minimum package is available.
     -- Tax credits/subsidies for certain small employers are available.
     -- Self-employed and unincorporated businesses can deduct 100% of their premiums.

   * If employers purchase coverage and achieve a specified coverage target, there is no requirement to provide private insurance or participate in the federal public health insurance plan ("public plan").

2. All businesses with more than 100 employees must provide private health insurance (for a specified benefit package) or contribute to the public plan for all employees and non-working dependents.

3. The public plan will cover employees and dependents that contribute and non-working individuals who buy in or are subsidized.

   * The plan replaces Medicaid for the specified services and pays providers according to Medicare rules.

   * The fully phased-in plan is financed and administered primarily by the federal government, although states can opt to administer it.

4. The minimum benefit package includes primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

5. System reforms include measures to contain costs, assure quality and initiate innovative delivery systems for the underserved.

6. For both administrative and fiscal reasons, the plan will be phased in, beginning with making coverage available for children through the public plan.

7. At full implementation, all Americans will be required to have health insurance through their employer or the public plan.

Phase-In Schedule and Cost of the Commission Health Care Proposal

(Dollars are in Billions, 1990)

Year 1

- Initiate Insurance Reforms.
- Allow all uninsured pregnant woman and children through age 6, to enroll in the public plan (fully subsidized to 185 percent of poverty).
- Raise Medicaid reimbursement rates for obstetrical and pediatric care.

Total Net New Federal Cost:	$3.4
% of Americans Without Health Insurance:	14%

Year 2

- Firms with fewer than 25 employees and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for the cost of health insurance that is provided. Employees of these firms with family income of less than 200 percent of poverty receive a subsidy.
- Public plan is available to uninsured children up to age 18.
- Improve physician reimbursement.

Total Net New Federal Costs:	$13.5-16.8
Additional Cost from Year 1:	$10.1-13.4
% of Americans Without Health Insurance:	8%-11%*

Year 3

- Firms with 100 or more employees are required to provide health insurance or contribute a portion of payroll to cover employees and dependents in the public plan.

Total Net New Federal Costs:	$17-20.3
Additional Cost from Year 2:	$3.5
% of Americans Without Health Insurance:	6%-8%*

Year 4

- If 80% of uninsured employees of firms with 25-100 employees (as of year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- Raise Medicaid hospital reimbursement rates.

Total Net New Federal Costs:	$19.8 - 23.1
Additional Cost from Year 3:	$2.8
% of Americans Without Health Insurance:	5%-7%*

Year 5

- If 80% of uninsured employees of firms with fewer than 25 employees (as of year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- Allow all uninsured adults into the public plan.
- Retain subsidy to small firms with low wage employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 4:	$11.8
% of Americans Without Health Insurance:	0%**

Year 6

- Retain subsidy to small firms with low wage employees and their employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 5:	$0

Year 7

- Eliminate explicit subsidy to small firms with low wage workers and their employees.

Total Net New Federal Costs:	$23.4
Additional Cost from Year 6:	($8.4)

* Depends on how many smaller firms voluntarily choose to purchase health insurance.

** If 80 percent of uninsured workers and their dependents in firms of fewer than 25 are now insured the Secretary of Health and Human Services must submit to Congress a plan to insure any remaining uninsured. If employers with fewer than 25 do not meet this target, then the imposition of a requirement to cover all workers and their dependents or contribute to a public plan will ensure that all Americans now have health insurance.

Summary: Recommendations on Long-Term Care

THE PEPPER COMMISSION PROPOSAL PROVIDES HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES AND PROTECTION AGAINST IMPOVERISHMENT FOR PEOPLE IN NURSING HOMES.

1. The plan has three components.

   * Severely disabled persons of all ages are eligible for social insurance for home and community-based care.

   * The plan establishes a Nursing Home Program (NHP) for nursing home care to provide an ample floor of financial protection, ensuring that no one faces impoverishment.

   * In addition, all nursing home users are entitled to social insurance for the first three months of nursing home care. This "front-end" insurance allows people who have short stays to return home with resources intact.

2. Financing and administration

   * The federal government finances the home and community-based care program and the three-month "front-end" nursing home care.

   * The federal and state governments share financial responsibility for the NHP.

   * All three components of the plan are administered by the states according to federal guidelines.

   * States are responsible for cost containment, quality assurance and consumer protection within federal standards.

3. Private sector role

   * Private long-term care insurance fills gaps not covered by this plan, subject to government standards and oversight.

   * The federal government encourages the development of private long-term care insurance through clarification of the tax code.

4. The benefits will be phased in over time.

Phase-In Schedule and Cost of Commission Long-Term Care Proposal

(Dollars are in Billions, 1990)

Phase I

- Home Care to 200 hours per year

Home Care	$10.8
Nursing Home Care	$ 0.0
Total Costs Phase I	$10.8

Phase II

- Implement 3 Month Front-end Nursing Home
- Implement Nursing Home Program

Home Care	$10.8
Nursing Home Care	$12.8
Net Increase From Phase I	$12.8
Total Costs Phase II	$23.6

Phase III

- Increase Home Care to 400 hours per year
- Begin to Improve Nursing Home Reimbursement Rates

Home Care	$18.6
Nursing Home Care	$15.6
Net Increase From Phase II	$10.6
Total Costs Phase III	$34.2

Phase IV (Year 4)

- Fully Implement the Home Care Program
- Further Improve Nursing Home Reimbursement Rates

Home Care	$24.0
Nursing Home Care	$18.8
Net Increase from Phase III	$ 8.6
Total Costs Phase IV	$42.8

Net New Federal Costs of the Commission Proposal
(Billions of Dollars, 1990)

SOURCE OF EXPENDITURE	
Access to Health Care	
Public health insurance of non-workers	$12.4
Federal Contribution to the public plan	6.3
Tax Expenditure	6.7
Augmented Medicaid Physician and Hospital Payments	4.0
Less savings from Medicare, CHAMPUS, Medicaid	(6.0)
Sub-Total (Access to Health Care)	**$23.4***
Access to Long-Term Care	
Home Health Care for the Severely Disabled Elderly (includes cost-sharing)	15.0
Home Health Care for the Severely Disabled Non-Elderly (includes cost-sharing)	9.0
Nursing Home Care for the Severely Disabled Elderly	16.8
Nursing Home Care for the Severely Disabled Non-Elderly	2.0
Sub-Total (Access to Long-Term Care)	**$42.8**
Total Net New Federal Expenditures	**$66.2****

*Phase-in plan includes the cost of temporary tax credits/subsidies for certain small businesses. Those costs are not reflected in these totals, which represent the cost at full implementation.

**Program costs are larger than the net new federal expenditures. On health care, states maintain Medicaid spending on services absorbed by the new public plan. On long-term care, states share in the cost of the Nursing Home Program with initial amounts equivalent to state Medicaid spending on long-term care services covered by the overall plan.

PEPPER COMMISSION RECOMMENDATIONS ON ACCESS TO HEALTH CARE

Structure of Job-Based/Federal Public Health Insurance Plan

1. Employer Responsibilities (in businesses with more than 100 employees and smaller businesses only if a specified coverage target is not met):

   * All businesses are required to provide private health insurance for at least the specified benefit package to all employees (and non-working dependents) or contribute to the public plan on their behalf.

   * If employers choose to provide private insurance, they must pay at least 80% of the premium for full-time workers and their non-working dependents and a share of the premium for part-time workers and their non-working dependents.

   * Alternatively, employers may contribute to the public plan for coverage for their employees and non-working dependents. The contribution will be equal to a percentage of payroll. The percentage will be set at a level that encourages employers who now purchase private insurance to retain that coverage and establish a fair balance of additional coverage responsibilities between the private and public sectors.

   * Employers may choose to purchase private insurance for their full-time workers and contribute to the public plan for part-time workers.

2. Individual responsibilities

   * All workers receive the specified benefit package through their own employer, although they may receive extra benefits from their spouse's employer. Rules, consistent with tax policy, determine the plan to which children are assigned.

   * Individuals pay up to 20% of the premium for private insurance.

   * To participate in the public plan, individuals who are working pay a percentage of wages as their share of the premium. Self-employed and non-working individuals pay the cost of the plan, subject to their ability to pay. People with incomes below 100% of poverty pay nothing and no one with an income below 200% of poverty would pay more than three per cent of income for the premium for adults or one percent of income for the premium for children and pregnant women.

   * For low income people, whether covered by the public plan or private insurance, premiums and cost-sharing are subsidized by the federal government. Individuals or families whose income is under 100% of the federal poverty level pay no premiums, deductibles or coinsurance. Individuals or families whose income is up to 200% of poverty at a minimum will pay premiums, deductibles and coinsurance on a sliding scale.

* At full implementation, individuals must obtain health insurance through their employer or the public plan.

3. Public Plan

* At full implementation, the public plan is financed and administered primarily by the federal government. As under Medicare, insurers may administer claims and may, under contract, offer managed care options. States also may administer claims.

* The public plan pays providers for the specified services with rates set according to the rules of the Medicare program.

* The public plan subsumes Medicaid for the specified benefits. Medicaid remains intact for all services not covered by the package.

* Participation in the public plan is financed through:

  -- employer contributions
  -- individual contributions
  -- federal revenues
  -- state contributions equal to Medicaid expenditures for covered services, adjusted for general inflation

4. State Role

* State governments no longer have responsibility for providing the specified benefit package for their low income residents. The new public plan replaces Medicaid for those services. Medicaid is retained for services not included in the package.

* States contribute to the public program as specified above.

* A state, at its option and subject to federal rules, can administer the public plan. All aspects of the administration must be conducted through a new agency which is unconnected to the welfare or Medicaid departments.

* States retain the responsibility for regulating financial stability of insurers.

5. Specified Benefit Package

* Basic services including hospital and surgical services, physician services, diagnostic tests and limited mental health services (45 inpatient days and 25 outpatient visits).

* Preventive services including prenatal care, well-child care, mammograms, pap smears, colorectal and prostate cancer screening procedures and other preventive services that evidence shows are effective relative to cost.

* Early, periodic, screening, diagnosis and treatment services (EPSDT) are included for children in the public program. Privately insured families can buy this coverage for their children from the public plan at cost (or at a subsidized rate for families under 200% of poverty).

* Deductibles are $250 for an individual and $500 for a family. Coinsurance is 20% for all services except prenatal care, well-child care, mammograms and pap smears, which have no coinsurance, and limited mental health services which have 50% coinsurance. The maximum a person or family must spend out of pocket is $3,000 in a year.

* One year after the effective date of this plan, the Office of Technology Assessment shall report to the Secretary on an assessment of the cost-effectiveness of prescription drugs for the purpose of inclusion in the benefit package as a preventive service.

Assistance for Small Business

1. Insurance reforms and a minimum benefit package will make obtaining private insurance for small groups more predictable and affordable. (See below.)

2. To stimulate voluntary coverage, employers with fewer than 25 workers and average payroll below $18,000 will be eligible for tax credits/subsidies for 40% of the cost of health insurance for workers and their dependents. After the tax credit/subsidy for employers of ten employees or less ends, businesses of ten employees or less, previously eligible for the credit, who are at extreme financial risk would be allowed to purchase coverage from the public plan at a percentage of payroll. This specific percentage of payroll would be consistently set at a relatively low rate to ensure affordability.

3. No employer with fewer than 100 workers would be required to purchase coverage or contribute to the cost of coverage if coverage targets were met voluntarily. (See phase-in schedule for details.)

Insurance Market Reform

1. For all employment-based health insurance:

   * No pre-existing conditions exclusions.

   * No denial of coverage for any individual in the group.

2. For those who wish to sell a health insurance product to employers in the small group market new rules would apply:

   * Guaranteed acceptance of all groups wishing to purchase insurance.

   * Insurers would set rates on the same terms to all groups in specified areas.

* Rates may not be increased selectively for any group enrolled in a plan.

* Enrollment would be for a specified minimum period.

* States would be restricted from regulating the content of health insurance benefits, but benefits would be standardized, to the extent possible, across carriers. At least one basic benefit package would have to be offered by each insurer in the small group market.

* Managed care plans would be required to be offered to small groups if such plans are available to larger employers in the area.

* A self-financed voluntary reinsurance mechanism through which insurers could reinsure high-risk persons or groups would be established.

Quality Assurance

1. The federal government should develop and implement a comprehensive national system of quality assurance which includes:

   * The development of national practice guidelines and standards of care, already begun by the newly created Agency for Health Care Policy and Research. Physicians and physician organizations should be widely utilized in establishing and reviewing practice guidelines and standards of care.

   * The development and implementation of a uniform data system that covers all health care encounters, regardless of payment source or setting. These data would provide a common foundation for all payers' quality assessment activities and for examining the effectiveness of medical care and identifying health policy and research concerns.

   * The development and testing of new, more effective methods of quality assurance and assessment.

   * The development and oversight of local review organizations that have skills in data integration and analysis, quality assessment and quality assurance.

2. The Prospective Payment Assessment Commission and the Physician Payment Review Commission will be directed to will convene experts, providers, lawyers and consumers to study and conduct demonstration projects related to medical malpractice reform in order to make recommendations to Congress on actions to be taken on the federal level. The appropriate committees of jurisdiction in Congress should also hold hearings on the malpractice issue.

Cost Containment Initiatives

1. Insuring all Americans through a job-based/public program and reforming the private insurance market will distribute the costs of insurance more fairly by:

   * Reducing the cost-shift that now occurs from the uninsured to the insured population.

   * Reducing the cost-shift that now occurs from employers who do not provide insurance to employers who cover their workers and dependents.

   * Assuring small business access to a minimum benefit package at predictable rates, regardless of employees' health status.

2. Adoption of a quality assurance strategy (described above) and reform of the medical malpractice system will assure greater value for the dollar in the delivery of medical services.

3. Measures to promote efficiency in provider payment would include:

   * Cost-sharing in the minimum benefit package that makes consumers sensitive to price.

   * Insurance reform that leads insurers to compete around efficient service delivery, rather than competing for "good" risks.

   * Extending "managed care" to small employers and including "managed care" as a means to provide the minimum benefit package in private insurance and the public plan.

   * Extending Medicare payment rules to the public program, which, in turn, serves as a model for private insurance.

   * Recommending that the Prospective Payment Assessment Commission and the Physician Payment Review Commission review costs under the program proposed by the Commission assess cost experience and initiatives to contain costs in the public and private sectors and to make periodic recommendations to the Congress on federal initiatives.

Delivery Issues

1. Expanding health care insurance coverage should reinforce --not replace -- support for primary care delivery systems targeted at the poor and underserved. Organized primary care providers (e.g., local health departments and community health centers) should be recognized and reimbursed by private and public payors on the same basis as all other providers.

2. The federal government should:

* Promote an adequate supply and appropriate mix of personnel and facilities for underserved areas and populations through mechanisms including:

  -- Provider payment methods in public programs that promote the availability of primary care practitioners and facilities and assure access to other needed services;

  -- Special initiatives (such as the National Health Service Corps and other financial incentives) to attract a range of providers (physicians and other practitioners) to underserved areas, and to assist such providers through mechanisms such as professional backup systems and support networks for rural providers (e.g., telecommunications with other professionals and facilities, mobile medical services).

* Support local efforts to develop outreach and facilitating services, for example, health education, transportation, home visiting, and translation services -- preferably linked to health care delivery programs -- to facilitate access to services and to encourage patients to seek and continue participation in health care.

* Support local efforts to reduce organizational and bureaucratic barriers to access through efforts such as the coordination and/or co-location of medical, welfare and social services (e.g., medical referrals, nutrition counseling and eligibility determinations for welfare and housing programs).

* Undertake and support research and evaluation efforts to determine the effectiveness of primary care models and services aimed at addressing the needs of underserved communities.

* Support programs of health promotion, disease prevention, risk reduction and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles. Federal support for such programs should total at least $1 billion annually beyond current federal efforts.

* Support an effective continuum of care, including short-term hospital-based and/or longer-term community based alcoholism and other drug treatment services.

Phase-In Schedule

Phase I (Year 1)

* Institute insurance reform.

* Allow all uninsured pregnant women, and children ages 0-6, to enroll in public plan, if they are from non-working

families or in families of workers whose employers do not provide coverage. Costs would be subsidized, according to ability to pay, at least for those with family incomes below 200% of poverty.

* Begin to improve reimbursement to providers for persons now served by Medicaid.

Phase II (Year 2)

* Firms with 0-25 workers and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for cost of coverage if they provide it. The subsidy would be available for five years.

* The public plan is made available to uninsured children up to age 18 (those from non-working families or families where workers' employers do not offer coverage). Subsidies would be available based on ability to pay, at least for those with family incomes below 200% of poverty.

Phase III (Year 3)

* Firms with 100 or more workers are required to provide private insurance coverage or contribute a portion of payroll toward the cost of covering employees and dependents in the public plan.

Phase IV (Year 4)

* If 80% of uninsured employees of firms with 25-100 workers (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide private insurance coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to cover those still left out.

Phase V (Year 5)

* If 80% of uninsured employees of firms with 0-25 workers (as of Year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to increase coverage options for employees (and their non-working dependents) who are not covered by their employers.

* All non-working adults are covered through the public plan.

Phase VI (Year 6)

* Congress considers the Secretary's recommendations.

* All individuals are required to have insurance coverage through their employers or through the public plan.

Revenues for Health Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

PEPPER COMMISSION RECOMMENDATIONS ON LONG-TERM CARE

Structure of the Plan

1. Social Insurance for Home and Community-based Care

   * Severely disabled individuals of all ages are eligible for this program. This includes individuals who need hands-on or supervisory assistance with three out of five ADL's (Activities of Daily Living) (eating, transferring, toileting, dressing, bathing), or who are severely cognitively impaired.

   * Eligibility is determined by a state/local government or federally-funded non-profit assessment agency using standardized assessment criteria. This agency conducts annual audits of case managers (described below) and monitors the quality of care.

   * Case managers determine the number of hours of care and mix of services the beneficiary receives.

     -- The case manager develops an individual care plan tailored to needs of the beneficiary. The availability of informal supports is included in the decision to allocate resources.

     -- The case manager operates within a budget set by the federal government, and conducts periodic reassessments of the beneficiary with special consideration to be given to cost containment. The case manager budget, in conjunction with other available services, will be sufficient to provide all services, needed by the patient.

   * The benefits include:

     -- Home health care
     -- Physical, occupational, speech and other appropriate therapy services.
     -- Personal care services (feeding, transferring, personal hygiene)
     -- Homemaker chore services (meal preparation, laundry, housework)
     -- Grocery shopping and transportation
     -- Medication management
     -- Adult day health and social day care
     -- Respite care for caregivers
     -- Cost-effective training of family members for delivery of home-based family care, and support counseling of family caregivers.

2. Nursing Home Program (NHP)

* Individuals of all ages who are determined eligible for nursing home care by a federally certified assessment agency are covered by this program for the entire length of their stay.

* The plan treats income and assets as follows:

  -- The plan protects $30,000 in non-housing assets for single individuals and $60,000 for couples.
  -- The plan provides a housing allowance equal to 30% of monthly income for the first year of a nursing home stay for single persons and, for married persons, as long as the spouse is alive, but at least a year.
  -- The plan provides a $100/month personal needs allowance.
  -- The plan provides income protection for the spouse living in the community up to 200% of the poverty level for a couple.
  -- Any remaining income goes toward the cost of the nursing home care.

3. Three-Month Front-end Coverage: Protection to Return Home

* All nursing home users are covered for the first three months of care with full protection for their income and assets, except for a modest copayment.

* Benefits include:

  -- Skilled nursing care
  -- Custodial care

Individual Role

1. Home and Community-based Care

* Individuals pay 20% of the costs of care up to a maximum of the national average cost of home and community-based care.

* The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

2. Nursing Home Program

* Individuals contribute their income toward the cost of care minus the housing and personal needs allowances.

* Individuals contribute non-housing assets above $30,000 for single persons and $60,000 for married persons.

3. Three-month "Front-end" Nursing Home Care

   * Individuals pay 20% of the costs of care up to a maximum of the national average cost of nursing home care.

   * The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

Financing

1. The federal government is responsible for the home and community-based care program and the three-month "front-end" nursing home care program.

2. The federal and state governments share the financial responsibility for the NHP.

Administration

1. The federal government contracts with states to administer all three components of the plan.

2. The federal government sets standards and guidelines for administration. These include the following:

   * Standardized assessment criteria for determining eligibility for home and community-based care and nursing home care.

   * Certification of assessment agencies.

   * Guidelines for certifying case managers.

   * Determination of case manager budgets.

   * Determination of provider payment rates for home and community-based care and nursing home care.

3. State administrative functions include the following:

   * Building on the current infrastructure for management and delivery of services, where long-term care programs already exist.

   * Designing and implementing the system for managing and delivering services, in states without existing programs.

   * Certifying providers.

   * Establishing the review and appeals process.

Private Sector Role

1. Private long-term care insurance fills gaps not covered by this plan.

2. The federal government encourages the development of private long-term care insurance through clarification of the tax code. This includes:

   * Treating, for tax purposes, the premiums paid and the benefits received as health insurance.

   * Enabling qualified long-term care policies to be sold in employers' cafeteria plans.

3. The federal and state governments share responsibility for standards and oversight of the private long-term care market.

   * The federal government establishes minimum standards which private long-term care policies must meet to be eligible for the tax clarification. It establishes methods of disseminating to consumers non-biased, professional information regarding private long-term care policies.

   * States regulate private long-term care insurance, using federal or stricter standards. The federal government will encourage states to strengthen civil penalties for misrepresenting policy standards, knowingly selling duplicative insurance or marketing unapproved policies by direct mail. In addition, states should train benefits specialists regarding private long-term care insurance and the availability of state information on that insurance.

Phase-In Schedule

Phase I

   * A maximum of 200 hours of home care per year is made available to all severely disabled persons.

Phase II

   * The three-month "front-end" nursing home care benefit is made available to all eligible nursing home users.

   * The nursing home program is implemented providing income and asset protection for all eligible nursing home users.

Phase III

   * The maximum hours of home care available per year is increased to 400.

   * Begin to improve nursing home reimbursement rates.

Phase IV

   * The home care program is fully implemented.

   * Further improve nursing home reimbursement rates.

Research Agenda for Long-Term Care

1. The federal government should move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying and dealing with long-term illnesses and disabilities. This effort should include research on outcome measures and national practice guidelines in long-term care. That effort should move toward a funding level of $1 billion annually and should do the following:

   * Explore how to reduce the risk for certain physical and mental disorders (e.g, Alzheimer's disease, osteoporosis, breast cancer, urinary incontinence) that are associated with increased need for long-term care

   * Examine how to enhance the quality of long-term care including the integration of services and case management.

   * Improve functional assessment tools to best target services to populations in need of care

   * Examine the special long-term care problems of subpopulations such as disadvantaged racial and ethnic minorities and the rural elderly and nonelderly disabled.

   * Evaluate the implementation of the home and community-based care program.

Revenues for Long-Term Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

   1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

   2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

   3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

3·8·90

RATIONALE FOR PEPPER COMMISSION HEALTH CARE PROPOSAL

Why do we need a national health care strategy?

Thirty-two million Americans -- more than a quarter of them children -- lack health insurance. Medicaid, our medical safety-net, covers only 42 percent of the nation's poor. Businesses, facing high and rising costs, are more frequently passing these costs along to their employees by increasing employee cost-sharing and by reducing health care benefits. Small businesses find that insurers often charge prohibitive rates or deny coverage to employees or their dependents who are considered poor health risks.

People without insurance are forced to go without care when they need it, often wait until their health condition is severe before seeking care. As a result, they are in poorer health than the insured. And the health care system, the facilities and providers from which we all receive care, is sagging from the burden.

The Commission's recommendations would address these problems by building a system that assures all Americans comprehensive health care coverage.

Why is the plan job-based?

Most Americans, 85 percent of all workers and their families, receive job-based health insurance today. Among the uninsured, 81 percent work or are dependents of workers. By extending job-based coverage, and building a public system alongside it, the Commission recommendations achieve universal coverage with minimal disruption to individuals and institutions.

Why does the plan give special consideration to small businesses?

Small firms are a growing part of our economy and one that we all want to preserve and encourage. Problems of health insurance availability and affordability are most critical in small firms, particularly those with low-wage employees.

To address these problems, the Commission recommends insurance reforms designed to increase the availability of comprehensive health insurance packages in the small group market. In addition, the Commission recommendations include special tax incentives to help small businesses with low-wage employees, giving the most assistance to the most vulnerable of small businesses.

Why does the plan include insurance reform?

Businesses are finding it increasingly difficult to find affordable health care coverage for their employees. Affordable basic benefit packages are often not available, and insurers increasingly avoid or charge prohibitive rates to employers whose workers are perceived as "high risk."

To address these issues, the Commission recommends changes in the rules by which insurers operate. Insurers would no longer be bound by state mandates relating to covered benefits and providers, ensuring the availability of low cost comprehensive coverage. In addition, they would be prohibited from denying coverage based on preexisting conditions in group plans.

To assist small businesses, the plan requires insurers, that choose to participate in the small group market, to accept all groups wishing to enroll and to set rates on the same terms for all groups in specified areas.

Why does the plan eliminate the Medicaid program and replace it with a federally administered program?

Federal law and related state options severely limit the number of low income individuals and families eligible for health care coverage through Medicaid. Childless couples, able-bodied single adults, and, families with dependent children whose income and/or assets exceed AFDC levels in their state are ineligible for Medicaid. States determine eligibility, the scope and duration of services, and reimbursement rates, so programs vary from state to state. As a result, the Medicaid program covers only 42 percent of the poor in America.

The Commission plan establishes a comprehensive federal health care program, with nationwide, uniform eligibility criteria and benefits, available to all who are not otherwise insured. The program continues our tradition of providing special protection to the poor, by subsidizing premiums, deductibles, and coinsurance in the public plan.

Why do we need a comprehensive, national system of quality assurance?

To ensure that every American receives the best value for the dollar, the Commission recommends that a four-pronged quality assurance program be adopted. The program would include national practice guidelines and standards of care; enhanced data to support quality assurance activities; improved approaches to quality assessment and assurance at the local level; and a national focus for developing, implementing, and monitoring a national system.

Why do we need cost containment?

Businesses and employees alike have expressed deep concern about the escalation of health care costs from year to year. To restrain growth in the cost of employee benefits, many businesses are reducing or limiting health care coverage. Individuals are finding that their health insurance is covering less and less of the cost of health care services needed by their families. Businesses and health care consumers are also concerned about effects of uncompensated care and cost-shifting that occurs between employers that provide health insurance and those who do not.

To constrain escalating health care costs and to address some of the related issues, the Commission recommendations include cost containment strategies that aim to (1) distribute the cost of insurance more fairly, (2) assure greater value for the dollar, and (3) promote efficiency in provider payments.

Why are delivery system recommendations included?

Barriers to access will persist, even if all individuals are insured. Such barriers include infrastructure problems (such as the dearth of health care providers in rural areas and the inner cities), as well as other nonfinancial barriers to access (such as language barriers, lack of transportation, and cultural factors). Accordingly, the Commission recommends continuation of existing federal programs designed to address the problems of underserved areas and populations. These programs should include those that promote outreach, education and research and an adequate supply and mix of facilities and providers.

Why does the plan phase-in coverage?

The Commission recommendations are phased in over time to build a universal system with minimal disruption to individuals and providers. Given the moral imperative to improve the overall status of child health and to extend health care coverage to all children, the recommendations provide children and pregnant women access, to coverage through the public plan, in the first phases. Businesses will, in later phases, cover all employees, and the public plan will be extended to additional uninsured adults.

HEALTH CARE: QUESTIONS AND ANSWERS

Q. Why did the Pepper Commission choose a job-based/public approach to health care coverage?

A. The Commission considered a number of alternative approaches to coverage -- ranging from Medicaid expansion and individual vouchers to government-run national health insurance. The Medicaid expansion/voucher approach would cost the government more than the Pepper Commission recommendations and still leave 14 million Americans uninsured. National health insurance would place the full burden of health care financing on the taxpayer and would replace a health insurance system that, with some adjustments, can continue to protect the vast majority of Americans.

Most working Americans and their families (80%) get health protection through the workplace; and most people without insurance (80%) are workers or in workers' families. The job-based/public approach extends job-based coverage to all workers, shares costs fairly among employers, taxpayers, and individuals, and avoids disruption by fixing rather than replacing our current insurance system.

Q. The recommendations would require employers to insure their workers. Isn't this putting too big a burden on employers?

A. Over 90% of all firms with more than 25 employees already cover their workers; and about half of even the smallest firms (fewer than ten employees) cover theirs. All these firms would actually save money under the Commission's recommendations, because they'd no longer pay for other people's workers and the uninsured.

Firms that don't offer coverage, most of which are small, get the opportunity they've been seeking to buy affordable health insurance -- minimum benefits offered to all comers, whatever their health status. They get substantial tax credits to cushion the costs or, if they're required to purchase, access to an affordable public plan.

Q. Some say that requiring employers to insure their workers will cost workers their jobs. Is that true?

A. Only a minority of workers are affected at all by the new employer requirements, since most are already covered. And those newly covered get assistance to keep their costs reasonable. Just as all workers are entitled to a decent minimum wage, they should be entitled to decent health care protection.

Q. What does the Commission recommend to contain health care costs?

A. The recommendations make insurance more affordable by virtually eliminating the "hidden tax" the insured now pay for the uninsured (through uncompensated care), by eliminating the subsidy from businesses that provide insurance to businesses that do not, and by reforming insurance industry practices that exclude or charge prohibitive rates to some firms.

The recommendations also aim to assure value for the dollar in the health care system by proposing enhanced quality assurance and, ultimately, malpractice reform. And, finally, the recommendations would promote efficient provider payment by including cost-sharing in the minimum benefit package, promoting managed care, and building upon new physician and hospital payment mechanisms evolving in Medicare.

Q. Where will the money come from to pay for the benefits the Commission recommends?

A. In its recommendations, the Commission not only made a strong statement of commitment to raising needed revenues but also specified guiding principles for selecting revenues sources: that revenues be progressive, that they come from all age groups, and that they assure adequate growth to support stable financing.

The Pepper Commission provides a blueprint for building a universal health and long-term care system. As the American people come to see and support that system, they will demand that Congress and President find the revenues to finance it.

RATIONALE FOR THE PEPPER COMMISSION'S LONG-TERM CARE PROPOSAL

Why Do We Need A New Public Policy for Long-Term Care?

Financing long-term care is a looming crisis in our society. Virtually every American lacks adequate protection against the need for long-term care -- approximately nine million Americans of all ages are in need of long-term care right now, one-third of them with severe disability.

The need for intensive long-term care is a financial catastrophe. At $2,000 per month, even a short stay in a nursing home absorbs substantial resources, and intensive home care, at an estimated $1,100 per month for the severely disabled, is not far behind. Currently, the bulk of long-term care is provided informally by family and friends; formal, paid care, whether at home or in a nursing home, is financed primarily out of people's own resources. Public programs, primarily Medicaid, cover institutional care only after people have exhausted all their own resources. Only a fraction of care provided at home or in the community is covered by public programs. And while private long-term care insurance has experienced much growth in the last three years, less than four percent of the elderly population currently holds policies. Persons who are already disabled are not eligible for private insurance, and most of today's healthy elderly cannot afford to purchase policies. The future affordability and adequacy of protection remain uncertain.

Why Does the Plan Provide Social Insurance for Home and Community-Based Care?

Following in the tradition of Medicare, this program reflects a broad social commitment to making home and community-based care benefits available to all disabled persons, regardless of their financial resources. All Americans will contribute to, and all Americans will benefit from, this program. The primary intent is to ensure that all severely disabled persons living at home receive financial protection to cover the cost of care and to help them maintain their standard of living by keeping their resources intact.

Why is There Limited Social Insurance for Nursing Home Care?

The Commission proposes a two-part nursing home program. To keep costs in reasonable bounds, the recommendations provide full social insurance protection for disabled people who are either at home or likely to return home -- the latter being people who experience short nursing home stays, of three months or less. For longer nursing home stays, the more limited goal is to protect most people's life savings and eliminate the fear of impoverishment for themselves and their spouses.

Why is the Financing Shared Between Federal and State Governments?

Consistent with the way that Medicare is financed, the social insurance programs for home and community-based care and nursing home care are federal responsibilities. The Nursing Home Program replaces Medicaid. Since the states already have extensive experience in financing and administering long-term care through their Medicaid programs, the Commission plan proposes that they continue sharing this responsibility with the federal government.

Why is the Administration Shared Between the Federal and State Governments?

The federal standards required by this plan provide for uniformity across states, assuring that persons with similar disabilities will be eligible for similar benefits, regardless of where they live. At the same time, it is important to build on the extensive experience many states already have in the areas of assessment, case management and delivery of services. This shared administrative responsibility assures some uniformity with flexibility and room for innovation.

Why is There a Role for the Private Sector?

This public program leaves gaps in coverage for long-term care, particularly for better off people with long nursing home stays. The Commission's plan proposes that the federal government encourage the development of private long-term care insurance through clarifications of the tax code to help fill in some of these gaps. In order to assure consumer protection, the recommendations suggest state regulation of the private long-term care industry with minimum federal standards and oversight.

LONG-TERM CARE: QUESTIONS AND ANSWERS

Q. Why did the Pepper Commission recommend limited social insurance?

A. The Commission recommendations give primary emphasis to protecting individuals living at home or likely to return home after short nursing home stays. That's why there is full social insurance protection for home and community-based care and for the first three months of nursing home care. For people with longer nursing home stays, there is an ample floor of protection against impoverishment. Most people's life savings are fully protected, along with their homes and their spouses' incomes. Paying for long-term care will no longer rob disabled Americans of their resources and their dignity.

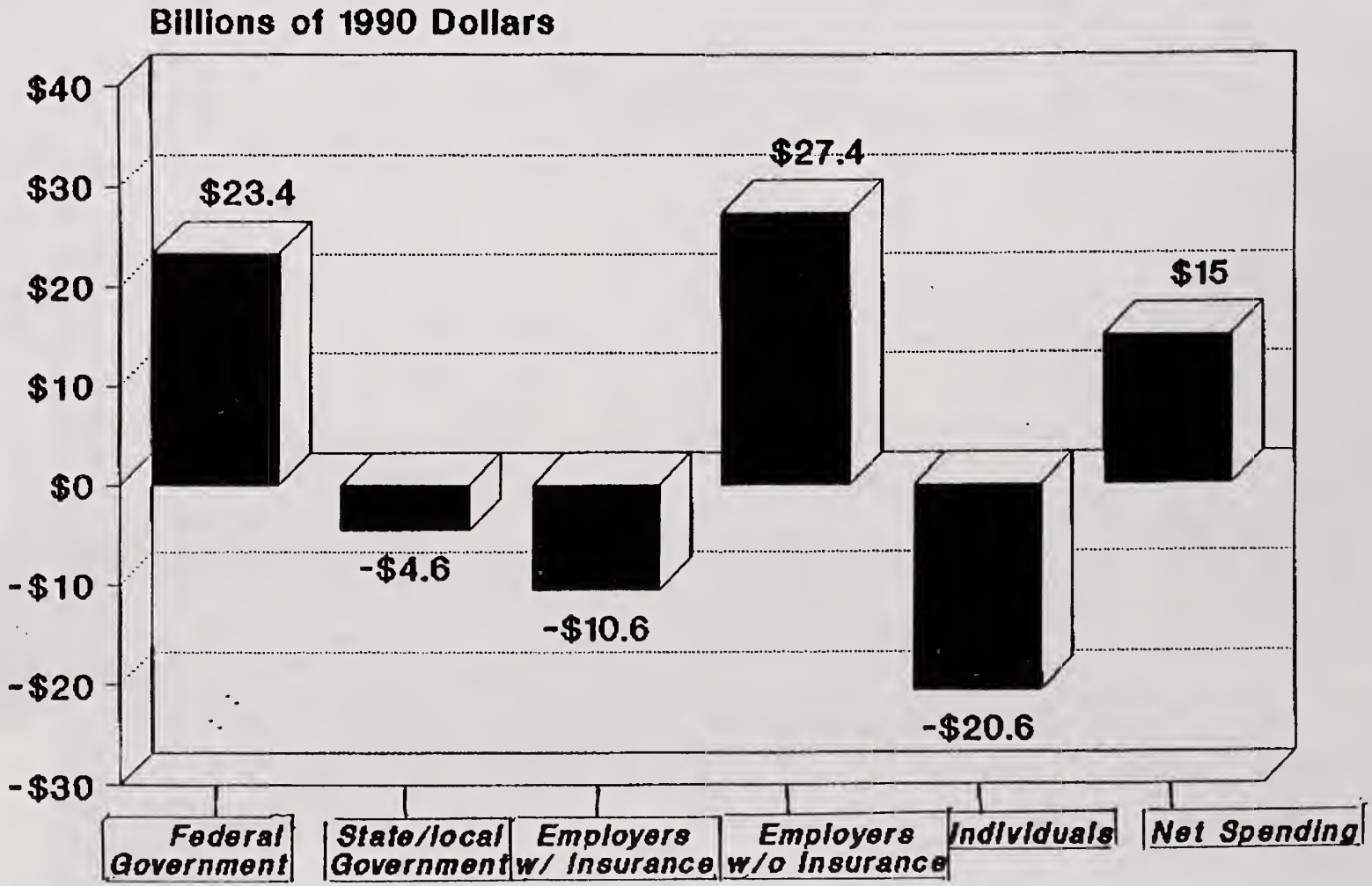
Q. Who would benefit from the long-term care recommendations?

A. All Americans would benefit from long-term care coverage, since any American is potentially at risk of needing long-term care. At any one time, the program would serve over three million severely impaired Americans of all ages, at home or in institutions, and would provide their families and friends desperately needed support and relief. Finally, the program would assist many not directly served by the program by encouraging the development of services that are now sorely lacking and promoting the availability of quality care.

Q. Do the Commission recommendations provide a role for private long-term care insurance?

A. Private insurance cannot guarantee all Americans protection against long-term care expenses, since most elderly cannot now afford it and persons already impaired are not eligible for coverage. But the proposed public program does not cover all expenses. Cost-sharing is required for home care and short nursing home stays, and people with long nursing home stays may want more protection of income and assets than the program provides. The recommendations therefore encourage the development of private insurance, subject to appropriate regulation and oversight, to fill these gaps.

Net New Social Health Care Spending Under Pepper Access-To-Health-Care Plan



(Health Care Spending Only)

Source: Lewin-ICF Estimates

OPTIONS FOR HEALTH INSURANCE COVERAGE: COSTS AND DISTRIBUTION

(IN BILLIONS OF 1990 DOLLARS)

Option	Net New Health Costs to Society	Net New Federal Expenditures	Net New State Expenditures	Net New Private Expenditures
I. Subsidize and improve access to private insurance and expand and improve Medicaid **Americans without health insurance = 14.4 million**	22	36	(4)	(10)
II. Pepper Commission Proposal **Americans without health insurance = 0**	14.0	23	(5)	(4)*
III. National Health Insurance **Americans without health insurance = 0**	8.0	222	(5)	(209)

* Employers who now provide health insurance will save $10.6 billion. Employers who now do not provide health insurance will spend an additional $27.4 billion. Individuals will save $20.6 billion in out-of-pocket and premium expenses.